Kansas Department on Aging

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING			С
		N046057				03/2	21/2012
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR				
ABERDEE	N VILLAGE		OLATHE, KS	119TH STR 6 66061	EEI		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS	3		S 000			
	The following citation complaint investigation	s represent the findings on #KS 55311.	s of				
S3028 SS=D	26-41-101 (f) (3) Staf Reporting	ff Treatment of Residen	ts	S3028			
	exploitation shall be ror operator of the factor of the allegation and hours. The administration that all of the followin (A) An investigation subministrator or operator operator operator of the followin (B) Immediate measurement further potent exploitation while the (C) Each alleged violation with the report. Results of the reported to the admin (D) Appropriate correst the alleged violation in (E) The department report shall be compliated to the department with initial report. (F) A written record significant in the shall be compliated in the department with initial report.	ective action shall be tak is verified. s complaint investigation	aware n 24 nsure i: e ress. y nitial sen if				
	This REQUIREMENT by: KAR 26-41-102(f)(3)(Γ is not met as evidenc	ed				
	1						1

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	N046057		B. WING		03/	C 21/2012
NAME OF PROVIDER OR SUPPLIER	1101000	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	1 00/	21/2012
NAME OF TROVIDER OR SOFT EIER			ST 119TH STR	•		
ABERDEEN VILLAGE		OLATHE, K				
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S3028 Continued From page	± 1		S3028			
sample included 3 res observation, interview facility failed to report unwitnessed falls whic of 3 residents sampled	and record review, the and investigate ch resulted in injuries fo	e				
Findings included:						
dated 6/30/11 listed af musculoskeletal syste difficulty walking, oster weakness, urinary trace hypertension, diabetes hypothyroidism, anem hyperlipidemia and systematical commendation of the resident assistance with bathin had impaired cognition problems, and memor understood other's verifalls and unsteadiness Level of Care/Assistar 7/29/11 recorded their for dressing, transfer, toileting, personal hyghad difficulty with recall-2 times per shift. The Agreement (NSA) date provided the resident's pendant alarm, adminimanaged the resident's pendant alarm, adminimanaged the resident's pendant service, daily licening and linens ar	ct infection, essential is mellitus type 2, hia, depressive disorder mbolic dysfunction. The creen dated 7/29/11 required physical hig, was usually contine in, short term memory by recall problems, usually communication, has and used a walker. The Plan Form dated resident was independent walking, continence arrigine tasks, and the resident en Requiring staff monitor is prevention and histered medications, its diabetes, provided ovided cues and reminits, provided personal	ery of fall, r, ne nt, ally ad he ent nd sident oring aff				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING		03/2	C 1/2012
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		<u></u>
ABERDEE	N VILLAGE		17500 WES OLATHE, K	ST 119TH STR S 66061	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S3028	Continued From page	2		S3028			
\$3028	REGULATORY OR LSC IDENTIFYING INFORMATION)		\$3028				
	was very confused. T 8/10/11 recorded the when he/she fell.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N040057		B. WING	C		
		N046057	OTDEET ADD	DEGG OFFICE	TE 7/D 00DE	03/2	21/2012
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
ABERDEE	N VILLAGE		OLATHE, K	EST 119TH STREET KS 66061			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S3028	Continued From page	3		S3028			
\$3028	recorded the resident responding briefly to see resident to the hospital. The hospital ER note resident admitted to the Unit (ICU) with a cere. Following the resident admitted to the facility 8/8/11 with a diagnose hemorrhage, (bleedin brain and the thin tiss. The hospital discharge recorded, "Acute ment secondary to left fronth hemorrhage, likely see The facility provided the Prevention, Intervential Investigation - Staff To Zero Tolerance Policy." It is the responsibility report to community moccurrence or suspect resident abuse from a covisitors, including injusiource The executive conjunction with the heads occurrence: state agency within 24 hours.	was very lethargic and stimuli, and staff sent that's ER. dated 8/6/11 recorded the hospital's Intensive of bral hemorrhage. It's hospital stay, the rest's skilled nursing unit of its of subarachnoid g in the area between the uest that cover the braine summary dated 8/8/1 stall status change, tall subarachnoid condary to recurrent fathe policy entitled Abuston, Reporting and reatment of Residents of dated 8/09 which direct of employees to prominangement any steed occurrence of negligible occurrence of negligible occurrence of negligible of an unknown the director or designed in the policy of employees director following of a suspected ate licensing/certifications"	the Care sident on the n.) 1 Illing." e cted, ptly ect or nily or or ed n	\$3028			
	report the incidents da the state reporting ag	use he/she did not kno	1 to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	
ANDILANO	1 CONTROL OF THE STATE OF THE S	IDENTIFICATION NUME	SEK:	A. BUILDING	<u> </u>		
		N046057		B. WING			C 21/2012
NAME OF DE	OVIDED OD CLIDDLIED	14040007	STREET ADDE	LESS, CITY, STA	TE ZID CODE	03/2	21/2012
NAME OF PE	ROVIDER OR SUPPLIER						
ABERDEE	EN VILLAGE		OLATHE, K	T 119TH STRI S 66061	EEI		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FI R LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3028	Continued From page	ge 4		S3028			
	unwitnessed falls w	report and investigate 2 hich resulted in injuries f I dependent resident.					
S3155 SS=G	26-41-204 (a) Healt	h Care Services		S3155			
	assisted living facilit facility shall ensure or coordinates the p care services that m resident and are in a	ator or operator in each ty or residential health cathat a licensed nurse proprovision of necessary hencet the needs of each accordance with the fundand the negotiated services.	ovides ealth ctional				
	by: KAR 26-41-204(a) The facility identified The sample include observation, intervie facility failed to provinterventions and ad	d a census of 39 resident d 3 residents. Based on ew and record review, the vide and apply effective sidequate supervision for 2 with a history of falls. (#1	e safety 2 of 3				
	Findings included:						
	dated 6/30/11 listed of musculoskeletal stall, difficulty walking weakness, urinary thypertension, diabethypothyroidism, and hyperlipidemia and Functional Capacity recorded the reside assistance with bath	emia, depressive disorde symbolic dysfunction. The Screen dated 7/29/11	gery of er, ne				

NAME OF PROVIDER OR SUPPLIER ABERDEEN VILLAGE TAGO WEST 1917H STREET CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STATE TAGORIES CITY, STATE, 2P CODE TYAGO WEST 1917H STREET CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STATE TAGO STATE TAGO STATE TAGO STATE PROVIDERS AND CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE OWNELL'S TAGO CONFLUTE PREFIX TAGO CROSS REFERENCED TO THE APPROPRIATE DATE OWNELL'S PREFIX TAGO CROSS REFERENCED TO THE APPROPRIATE OWNELL'S PREFIX TAGORISM REFERENCED TO THE APPROPRIATE OWNELL'S PREFIX TAGORISM REFERENCED TO THE APPROPRIATE OWNELL'S PROVIDERS AND REFERENCED TO THE APPROPRIATE OWNELL'S PREFIX TAGORISM REFERENCED TO THE APPROPRIATE OWNELL'S PREFIX PROVIDERS CITY, STATE, 2PD CORDETION (EACH COORSECTIVE ACTOR) (FACH COORSECTIVE PREFIX TAGORISM REFEX AND CORRECTIVE (FACH COORSECTIVE PREFIX TAGORISM REFIX AND CORRECTIVE (FACH COORSECTIVE (FACH COORS		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ABEROEEN VILLAGE (MA) 10 (MA					A. BUILDING B. WING	·······		_
ABERDEEN VILLAGE (X4) D			N046057				03/2	21/2012
DATHE, KS 66061 CATHE,	NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
S3155 Continued From page 5 problems, and memory recall problems, usually understood other's verbal communication and had falls and unsteadiness and used a walker. The Level of Care/Assistance Plan Form dated 7/29/11 recorded the resident independent for dressing, transfer, walking, continence and tolleting, personal hygiene tasks, and the resident had difficulty with recall requiring staff monitoring 1-2 times per shift. The Negolitaded Services Agreement (NSA) dated 7/29/11 recorded staff provided the resident's fall prevention and pendant alarm, administered medications, managed the resident's diabetes, provided education, bathing, provided cues and reminders for activities and meals, provided personal laundry service, daily bed making, weekly cleaning and linens and social transportation. The Assisted Living Health Care Service Plan (care plan) dated 7/18/11 directed staff to cue the resident's making weekly laundry, provide bathing assistance weekly and monitor the resident every 1-2 hours because the resident was a fall risk. The Fall Risk Assessment dated 7/29/11 recorded the resident's score was 18, and a total score of 10 or above represented high risk. The resident's score was 22 and on 8/5/11 the score was 22 and on 8/5/11 the score was 22. The physician's progress note dated 8/1/11 recorded the resident appeared to have difficulty with use of his/her walker, and the resident stayed on the assisted living unt to a temporary	ABERDEE	N VILLAGE				EET		
problems, and memory recall problems, usually understood other's verbal communication and had falls and unsteadiness and used a walker. The Level of Care/Assistance Plan Form dated 7/29/11 recorded the resident independent for dressing, transfer, walking, continence and tolieting, personal hygiene tasks, and the resident had difficulty with recall requiring staff monitoring 1-2 times per shift. The Negotiated Services Agreement (NSA) dated 7/29/11 recorded staff provided the resident's fall prevention and pendant alarm, administered medications, managed the resident's diabetes, provided deducation, bathing, provided cues and reminders for activities and meals, provided personal laundry service, daily bed making, weekly cleaning and linens and social transportation. The Assisted Living Heatth Care Service Plan (care plan) dated 7/18/11 directed staff to cue the resident for meals and activities, do weekly laundry, provide bathing assistance weekly and monitor the resident every 1-2 hours because the resident was a fall risk. The Fall Risk Assessment dated 7/29/11 recorded the resident every 1-2 hours because the resident was a fall risk. The Fall Risk Assessment dated 7/29/11 recorded the resident's Fall Risk Assessment score dated 7/31/11 was 18, on 8/21/11, the resident's fall risk score was 22, on 8/4/11 the score was 22 and on 8/5/11 the score was 22. The physician's progress note dated 8/1/11 recorded the resident appeared to have difficulty with use of his/her walker, and the resident stayed on the assisted living unit on a temporary	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		PREFIX	(EACH CORRECTIVE ACTURE CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
understood other's verbal communication and had falls and unsteadiness and used a walker. The Level of Care/Assistance Plan Form dated 77/29/11 recorded the resident independent for dressing, transfer, walking, continence and toileting, personal hygiene tasks, and the resident had difficulty with recall requiring staff monitoring 1-2 times per shift. The Negoliated Services Agreement (NSA) dated 77/29/11 recorded staff provided the resident's fall prevention and pendant alarm, administered medications, managed the resident's diabetes, provided education, bathing, provided cues and reminders for activities and meals, provided personal laundry service, daily bed making, weekly cleaning and linens and social transportation. The Assisted Living Health Care Service Plan (care plan) dated 7/18/11 directed staff to cue the resident for meals and activities, do weekly laundry, provide bathing assistance weekly and monitor the resident every 1-2 hours because the resident was a fall risk. The Fall Risk Assessment dated 7/29/11 recorded the resident score was 18, and a total score of 10 or above represented high risk. The resident's Fall Risk Assessment score dated 7/31/11 was 18, on 8/2/11, the resident's fall risk score was 22. The physician's progress note dated 8/1/11 recorded the resident appeared to have difficulty with use of his/her walker, and the resident stayed on the assisted living unit on a temporary	S3155	Continued From page	÷ 5		S3155			
on the skilled unit when a bed was available.		problems, and memorunderstood other's vehad falls and unstead The Level of Care/As: 7/29/11 recorded the dressing, transfer, wat toileting, personal hyghad difficulty with recat-2 times per shift. The Agreement (NSA) dat provided the resident' pendant alarm, admir managed the resident' pendant alarm, admir managed the resident education, bathing, provided the resident alaundry service, daily cleaning and linens and laundry service, daily cleaning and linens and laundry, provide bathir monitor the resident resident was a fall rist. The Fall Risk Assessing recorded the resident score of 10 or above resident's Fall Risk As 7/31/11 was 18, on 8/3 score was 22, on 8/4/8/5/11 the score was The physician's prograecorded the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident was a policy of the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident was a policy of the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident with use of his/her was stayed on the assisted basis pending what we was taken to the resident was ta	ry recall problems, usual repair communication and iness and used a walker sistance Plan Form data resident independent for liking, continence and giene tasks, and the resident requiring staff monitor in the Negotiated Services and 7/29/11 recorded start in the Services and reminal provided cues and reminal stered medications, and the resident of the Negotiated Services and reminals, provided personal bed making, weekly and social transportation in Care Service Plan (cairected staff to cue the difference activities, do weekly and assistance weekly and assistance weekly are severy 1-2 hours because k. The Service Plan (cairected staff to cue the difference activities, and weekly are severy 1-2 hours because k. The sessment dated 7/29/11 as score was 18, and a represented high risk. The sessment score dated (2/11, the resident's fall 11 the score was 22 ar 22. The sess note dated 8/1/11 appeared to have difficulting unit on a temporould be a safer placem ould be a safer placem ould be a safer placem.	d er. ed or sident oring aff ders . The are total The risk and on culty ent				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING		C 03/21/2012	
NAME OF DE	ROVIDER OR SUPPLIER	11040037	STREET ADDI	I RESS, CITY, STA	ATE ZIP CODE	03/2	1/2012
	EN VILLAGE			T 119TH STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S3155	to his/her bed and de Staff did not note any dated 8/8/11 (10 days the resident returned (admitted), and staff s least 1-2 hours when the resident to call for up. (The 1-2 hour moon the 7/18/11 care p The fall report dated 7 recorded the resident when staff arrived the floor in the bathroom on the shower floor an on the bathroom floor under the wooden bedenied hitting his/her inch abrasion on the reage, and assisted th resident then scream of pain when staff did the resident's right leg 8/9/11 (9 days after the complained of pain in The fall follow-up recobalance easily-remined 18th fall since Januar every 1-2 hours-need cueing." (The 1-2 hoplace on the 7/18/11 cand cueing was in plate of the place on the the resident fell again at 6 the staff did the resident fell again at 6 the staff d	he resident on the floor nied hitting his/her head injury. The fall follow-us after the fall) documer to the facility that day should check the reside awake, and staff remin assistance before gett nitoring was already in lan.)	d. p nted nt at ded ing place and the body dent 3 be ned n) on ed ident ' ance, ked ady in nding II.) the t the	S3155	DEFICIENCY)		
	The hospital chest x-r	ray report dated 8/1/11 series with chest x-ray.	·				

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING		02/2	
NAME OF PROVIDER	OD SLIDDLIED	N046057	STREET ADD	 RESS, CITY, STA	TE ZIP CODE	03/2	1/2012
ABERDEEN VILL				T 119TH STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
S3155 Conti	nued From page	e 7		S3155			
rib injof the is like acute non-atime is a chr. The f staff reside previeto wa of rig assis the refollow reside the h days, of his interv. The f the recurre. The recordiving Revie P.M. and t staff investigations.	jury and painThe left 8th rib. The ely the lateral aspect displaced rib fracture is with repeated stronically non-head found the resident complained cous fall and when lik to the bathroom his fall pain as, "I ted the resident to the hower and the resident to the hower and the resident was fall) record cospital, it was the and the resident when and the resident was the resident had a right for the pain as and the resident was the resident to the hower and the resident was the resident had a right for the resident that a right for the resident with the resident and the resident with the resident states of the resident states of the resident states of the resident states of the resident that a fall report dated a found the resident states of the resident that resident the resident that a fall report dated a found the resident resident that resident the resident that resident that a fall report dated a found the resident resident that resid	There is a non-acute fractive is an old fracture of vocation of the right 9th rib. acture is identified." (A either one that occurs of the are ling fracture.) 8/2/11 at 8:00 P.M. recont on the floor and the of right rib pain from the n staff assisted the resist on the resident complait bone on bone". Staff to bed, called 911 and spital's ER. The fall 11 (8 days after the ed staff sent the reside resident's 3rd fall in 4 to continued to be unawer were fall prevention.	what No over ea, or orded edent ned sent orded are orded				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		A. BUILDING B. WING		C 03/21/2012	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ABERDEE	N VILLAGE		17500 WES OLATHE, K	ST 119TH STR S 66061	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S3155	Continued From page	e 8		S3155			
	denied hitting his/her confused. The fall foll days after the fall) dir check the resident evand every 2 hours at unstable and was wa facility's skilled unit. (already in place on the The fall report dated staff witnessed the rebackward in the bath. The fall follow-up date resident's fall) directe every 1-2 hours relate resident needed cont dementia was increas cues/reminders to caresident was on hold skilled unit related to hour monitoring was 7/18/11 care plan, the in place since the 7/2 Review of the nurse's A.M. recorded staff for next to his/her bed and Facility staff did not dinitiate an investigation after this fall. The fall report dated a recorded staff found the floor with his/her kneed was very confused. 8/10/11 (4 days after resident was not aways was was a stage of the fall resident was not aways was was was was not aways was was was was was not aways was was was was not aways was was was was was not aways was was was was not aways was was was was was was was was was wa	Staff also noted the resist head but was very ow-up dated 8/10/11 (5 ected staff to continue the ry 1-2 hours during the right, the resident was siting for a bed on the The 1-2 hour monitoring the 7/18/11 care plan.) 8/5/11 at 6:00 P.M. reconsident as he/she fell froom and sat on the flood 8/10/11 (5 days after dots at the following the resident as the following and did not remember a bed on the facility increased falls. (The 1-calready in place on the facility increased falls.) In note dated 8/6/11 at 7 bund the resident on the facility increased falls.) In note dated 8/6/11 at 7 bund the resident on the facility increased falls. (The 1-calready in place on the facility increased falls.) In note dated 8/6/11 at 7 bund the resident on the facility increased falls. (The 1-calready in place on the facility increased falls.) In note dated 8/6/11 at 7 bund the resident on the facility increased falls. (The 1-calready in place on the facility increased falls.)	g was orded or. r the onitor e dent's ber e 's 2 was :00 e floor t fall. ot ons				

IDENTIFICATION NUMBE	IN.	A. BUILDING		COMPLETED
		A. BOILDING		С
N046057		B. WING		03/21/2012
11040007	STREET ADDR	ESS CITY STA	TE ZIP CODE	03/21/2012
			55 1	
		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETE
		S3155		
d living unit, and the g list for a bed on the glist for a bed on the line injured during this and then re-admitted of the re-admitted of the graph of the g	e the the fall, to e d the Care sident in the he.) I ling." /8/11 - n igh.			
sol lidger of the solution of	I since the resident living unit, and the glist for a bed on after the fall, and the injured during this d then re-admitted systems. It is in the living unit injured during this d then re-admitted systems and linear the fall, and the injured during this d then re-admitted systems and linear the fall, and staff sent the fall, and staff sent the fall, and staff sent the systems and linear the systems and linear the systems and linear the systems and left and right upper the left upper and left and right upper and left	I since the resident living unit, and the grist for a bed on the after the fall, and the injured during this fall, d then re-admitted to 3/11 at 11:30 A.M. very lethargic and li, and staff sent the R. ted 8/6/11 recorded the espital's Intensive Care nemorrhage. spital stay, the resident illed nursing unit on subarachnoid he area between the hat cover the brain.) mmary dated 8/8/11 status change, barachnoid ary to recurrent falling." sessment dated 8/8/11 pale skin and left and right upper arm and back of left thigh.	STREET ADDRESS, CITY, STA 17500 WEST 119TH STR OLATHE, KS 66061 ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) S3155 I since the resident I living unit, and the g list for a bed on the I prevention lace. The date on the after the fall, and the injured during this fall, d then re-admitted to S/11 at 11:30 A.M. very lethargic and li, and staff sent the R. ted 8/6/11 recorded the espital's Intensive Care memorrhage. sepital stay, the resident illed nursing unit on subarachnoid he area between the hat cover the brain.) mmary dated 8/8/11 status change, barachnoid ary to recurrent falling." sessment dated 8/8/11 pale skin and left and right upper t, the left upper arm and back of left thigh. sinary (IDT) note dated ded the resident in the hospital for hemorrhage, and had	STREET ADDRESS, CITY, STATE, ZIP CODE 17500 WEST 119TH STREET OLATHE, KS 66061 INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) Is since the resident Iliving unit, and the Il prevention lace. The date on the after the fall, and the injured during this fall, d then re-admitted to S/11 at 11:30 A.M. very lethargic and Iii, and staff sent the R. tete 8/6/11 recorded the spital's Intensive Care nemorrhage. spital stay, the resident lilled nursing unit on subarachnoid he area between the hat cover the brain.) mmary dated 8/8/11 tatus change, barachnoid ary to recurrent falling." sessment dated 8/8/11 pale skin and left and right upper the flupper arm and back of left thigh. sinary (IDT) note dated ded ded the resident in the hospital for hemorrhage, and had

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE S COMPLE	
				A. BUILDING B. WING			С
		N046057				03/	21/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ABERDE	EN VILLAGE		17500 WES OLATHE, K	ST 119TH STR (S 66061	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155	Continued From page	e 10		S3155			
	apartment, where he admitted to the hospi in mental status and was "very unsteady" note further described bruises on the back of the right back of the asmall bruise on the light green bruise to be well as a red mark (or slight redness on the large bump on the left buring an interview or administrative nursing 8/4/11 and 8/6/11 fall notes were usually concesident was found be he/she did not know the report and investigating staff B stated he/she intervention each time resident fell. One intervention each time resident fell. One intervention to the red was a behavior, that interventions to prevent the rewas a behavior, that interventions to prevent the rewas nothing mestated he/she identifies a bed on the skilled he/she offered the remove the resident to nursing unit instead of document that.	/she had frequent falls, tal on 8/6/11 with a cha confusion, and the resident on his/her feet. The ID of the resident's bruises ib area, a large bruise oback, a medium-large bene thigh on posterior as left medial knee, and a back of his/her her head la scar) on the left mid la left anterior hip area, a ft forearm. In 3/14/12 at 8:02 A.M., g staff B stated the resides recorded in the nurse onsidered a fall because by the staff on the floor, a why staff did not initiate on. Administrative nursitated to implement a neet to prevent falls after the resident every hour, but at and it was not assigned inistrative staff B stated esident fell on purpose, it was hard to come uppent the resident needed was why the resident were did nursing unit, and thousident's family the option another facility with a sident's family the option another facility with a sident's family w	dent of as 2 on ruise pect, n old d as back, nd a dent's 's e the and a fall ing w he atthey ed to and it with and her more aited ught n to killed				

NAME OF PROVIDER OR SUPPLIER ABERDEEN VILLAGE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	(X3) DATE SURVEY COMPLETED	LE CONSTRUCTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	OF DEFICIENCIES F CORRECTION	
NAME OF PROVIDER OR SUPPLIER ABERDEEN VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 17500 WEST 119TH STREET OLATHE, KS 66061 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: O3/21/2012 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) DATE: O3/21/2012	<u> </u>		A. BUILDING				
ABERDEEN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X6) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DEFICIENCY) (X6) DEFICIENCY)	03/21/2012		B. WING		N046057		
ABERDEEN VILLAGE OLATHE, KS 66061 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 COMPILED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						ROVIDER OR SUPPLIER	NAME OF PR
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						EN VILLAGE	ABERDEE
	VE ACTION SHOULD BE COMPLETE ED TO THE APPROPRIATE DATE	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PREFIX	BY FULL	CY MUST BE PRECEDED BY F	(EACH DEFICIENC	PREFIX
S3155 Continued From page 11 S3155			S3155		e 11	Continued From page	S3155
12/1/96 which directed residents would be identified for risk of falls and interventions implemented for reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status. The facility failed to implement effective interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status. The facility failed to implement effective interventions and failed to provide adequate supervision for this dependent resident with a history of falls, injuries and hospitalizations from falls. - Resident #2's Physician Order Sheet (POS) dated 11/11 listed diagnoses that included paralysis agitans, injury to spine and spinal cord birth trauma, fall, malaise and fatigue, difficulty walking, muscle weakness, palliative care, contact dermatitis, eczema, aftercare follow surgery musculoskeletal system, urinary tract infection, anemia, pneumonia, post traumatic wound infection, hypertension, hypertrophy prostate without urinary obstruction and hypoosmolality and/or hyponatremia. The Functional Capacity Screen dated 11/18/11 recorded the resident required physical assistance with bathing, dressing, the facility managed medications and treatments. experienced impaired cognition, the resident had short term memory loss, memory/recall, impaired decision making, had falls and unsteadiness and used a walker. The Negotiated Services Agreement (NSA) dated 11/18/11 recorded the resident's fall prevention and pendant alarm, medications, medication management and treatments, provided education, bathing, provided uses and reminders for activities and meals, provided personal				high-risk high-risk high-risk high-risk high-risk high-risk high-risk higher high propriate staff to uate with a cons from (POS) led inal cord lifficulty life, lillow y tract limatic phy life he is a life high properties and side of the staff high reminders in the life high properties and side of the l	ed residents would be alls and interventions are risk. Resident's high umented on the temporary of care reflecting approprize falls. Nursing staff by the system to alert staff to status. Implement effective led to provide adequate dependent resident with es and hospitalizations of the system to alert staff to status. In the system to alert staff to status and hospitalizations of the system and spinal status and fatigue, difficult alique and fatigue, difficult alique and system, urinary transcribed and system, urinary transcribed and system, urinary transcribed and system to and sor hyponatremia. The screen dated 11/18/11 are quired physical ing, dressing, the facilities and treatments, decognition, the resident ones, memory/recall, imperior of the system of the system and unsteadiness and treatments, decognition, medication and ications, medication and ications, medication and covided cues and reminications and reminications, provided covorided cues and reminications.	12/1/96 which directed identified for risk of faimplemented to reduct status would be docu and/or overall plan of interventions to minimity would implement a stresident's high-risk status. The facility failed to in interventions and fails supervision for this dhistory of falls, injuries falls. Resident #2's Physical dated 11/11 listed dia paralysis agitans, injubirth trauma, fall, mal walking, muscle wead contact dermatitis, easurgery musculoskel infection, anemia, phypoprostate without urina hypoosmolality and/of Functional Capacity frecorded the resident assistance with bathin managed medication experienced impaired short term memory lodecision making, had used a walker. The Nagreement (NSA) daprovided the resident pendant alarm, medical management and treeducation, bathing, p	

	OF DEFICIENCIES F CORRECTION	` '	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		N046057		A. BUILDING B. WING		03/3	2 1/ 2012	
NAME OF PR	OVIDER OR SUPPLIER	N046037	STREET ADD	 RESS, CITY, STA	TE, ZIP CODE	03/2	1/2012	
	N VILLAGE		17500 WES OLATHE, K	ST 119TH STR S 66061	EET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
S3155	Continued From page	: 12		S3155				
	laundry service, daily cleaning and linens at Noted, "Assistance reissues-Parkinson's dis Living Health Care Se 11/18/11 directed, cut daily bed making, weet trash pickup, weekly I resident, assist with dundressing related to disease, assist with be falls and Parkinson's transportation as need. Review of the resident the resident resident resident that during December resident had 31 falls. The fall report dated frecorded staff found to front of recliner. The foll days after the fall), needed, staff did frequesident's 7th fall, the tears, staff should concall staff for assistance treated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident to see a late of the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the resident for a said the fall report dated for a toe wour member was trying to the fall report dated for a toe wour member was trying to the fall report dated for a toe wour member was trying to the fall repor	bed making, weekly and social transportation belated to safety sease." The Assisted ervice Plan (care plan) de for meals and activitie ekly housekeeping with aundry, hang clothes for ressing daily and falls and Parkinson's athing related to safety disease, provide social ded. It's medical record revent the assisted living under 12/2/12. It's medical record revent the assisted living under 12/2/12. It's medical record revent the resident on the floor all follow-up dated 12/5 directed no change in usent checks, it was the resident got frequent sent and the resident was beind, and the resident was beind, and the resident set up an appointment Neurologist.	dated es, a daily or for aled ait aled 12 the sin 6/11 care kin at to angle amily a for ant, to ant,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDER/SUPPLIER/GIFICATION NUMB		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	NO	46057		B. WING		_	C 2/24/2042
NAME OF PROVIDED OR OURD		46057	STREET ADDI	<mark> </mark> RESS, CITY, STA	TE ZIR CODE	0	3/21/2012
NAME OF PROVIDER OR SUPPL ABERDEEN VILLAGE	ER			T 119TH STR			
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
assistance, staresident's side toe wound white family tried to. The fall report recorded staff to his/her dinir 12/6/11 (3 day in care needed checks, every constant remir wait for staff a incident, 6th fareceived treating would need not facility was wat appointments. The fall report recorded staff of his/her reclip 12/6/11 directed continue to cut assistance, the approximately should continuassistance, it is resident's fam changes becated to the fall report recorded staff fall follow-up of directed no changes decay to the required constitution of the resident's family fall follow-up of directed no changes decay the required constitution of the required constitution of the resident's family fall follow-up of directed no changes decay the resident's family fall follow-up of directed no changes decay the resident's family fall follow-up of directed no changes decay the resident's family fall follow-up of directed no changes decay the resident's family fall follow-up of directed no changes decay the resident's family fall fall follow-up of directed no changes decay the resident's family fall fall follow-up of directed no changes decay the resident's family fall fall fall fall fall fall fall fa	mind the resident aff should keep the the resident had set up a Neurolog dated 12/3/11 at found the resident new shoes after the fall), of the resident new shoes after he fall in the past 3 ment on his/her to we shoes after he fall found the resident new shoes after he fall found the resident on the resident was che every 1-2 hours to cue the resident was che every 1-2 hours to cue the resident was the 11th incidence of the resident was the resid	the walker at the diskin tears a leated and the gist appointm to 7:15 15 P.M. Into the floor follow-up dated frequer awake, needed frequer awake, needed frequer awaker and ealed and the leated and the leated and the leated for safety, it was the footbase of the floor for safety, standard for safety for s	nd a ent. ent. r next ed ange at ed d to 10th sident d front front front aff r the e fall), dent fety,	S3155			

		(X1) PROVIDER/SUPPLIER/O	IBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING			c	
		N046057		B. WING		03/2	21/2012	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ABERDEEN VILLAGE			17500 WES OLATHE, K	ST 119TH STR (S 66061	EET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S3155	Continued From page	e 14		S3155				
53190	bruised easily and haskin tears were not reshould continue to cut the facility waited for heal and for the neur resident's physician for resident's falls. The fall report dated recorded staff found the foot of his/her bed 12/8/11 (2 days after in care needed, staff resident every 1-2 hor remind the resident resident every 1-2 hor remind the resident resident's 14th incide bruising or skin tears waited for the follow waited for the follow waited for the follow and the recorded a family metried to sit in his/her rathefall follow-up date fall), directed no char should continue to chours and as needed use the recliner and to the resident to the resident of the resident to the resident of the resi	and frequent skin tears. Selated to falls, and staff the and remind the resident the resident's toe wound ology appointment and ollowed weekly regarding. The fall follow-up date the fall), directed no choominue to check the the fall follow-up date the fall), directed no choominue to check the the fall follow-up date the fall follow fo	ent, d to the ng the at ed ange nd the acility dent. ident oor. er the 1-2 not to ked t, and dent to sit	53155				
	12/10/11 directed no	change in level of care, eminders and checks, it	, staff					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		, ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
				A. BUILDING B. WING			С
		N046057				03/2	21/2012
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA	,		
ABERDEE	N VILLAGE		17500 WES OLATHE, K	ST 119TH STR S 66061	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155	minutes previously, the non-compliant with content again. The fall report dated recorded staff found front of his/her recline 12/15/11 directed no fall in the past 30 day increased issues with Parkinson's disease, to hire private duty content again. The fall report dated recorded staff suggested to the new chair (chair lift) for resident was a good skilled nursing unit. The fall report dated recorded staff found front of the chair at the resident slid out of the dated 12/29/11 (8 daresident needed a ched discussed private duresident's family and 2 hours in the morning evening, it was the reand the family would to resident fall issues low, and the resident. The fall report dated recorded staff found his/her bed. The fall found his/her bed. The fall four caregivers would asset the resident of the fall report dated recorded staff found his/her bed. The fall found his/her bed.	the resident had a fall 3 he resident was alling for assistance, an sident not to use his/he 12/14/11 at 8:45 P.M. the resident on the floorer. The fall follow-up da change in care needed ys, the resident had a mobility related to staff suggested to the faregivers for the resident's family to ge for the resident, and the candidate to move to the candidate to move to the faregivers for the fall follow-up safter the fall), directed angle in his/her care, staty caregivers with the they would provide care and 2 hours in the esident's 17th fall in 201 provide a new chair relation the chair that was a had unsafe walker practical transport of the control of the chair that was a had unsafe walker practical transport of the chair that was a ha	d r r in ted , 16th family nt, t a ne r in up ed the aff e for 1, ated s too ctice. of 1 duty of	S3155			
	Daily Living (ADLs) a	and bathing already in pur assistance, it was the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING		03/2	
NAME OF PR	OVIDER OR SUPPLIER	N046057	STREET ADD	 RESS, CITY, STA	ATE, ZIP CODE	03/2	1/2012
	N VILLAGE			T 119TH STR			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S3155	Continued From page	e 16		S3155			
	resident's 20th fall, a resident had a new refigure out how to use the resident every 1-2 fall reports and invest reported for 12/29/11. The fall report dated 1 recorded staff found the front of his/her recline 12/29/11 (7 days after resident needed a chafamily was interviewing provide care 4 hours in continue to assist the should check the resident's living room about moving the resident the following the resident was not stand had poor safety at the fall report dated 1 recorded staff found the front of his/her recline 1/3/12 (8 days after the following resident, continued to safety at the fall report dated 1 recorded staff found the fall report dated 1 recorded 1 recorded 1 recor	and the 4th fall that day ecliner but was not able it, and staff should che hours. (The facility lacigations for the other 2 h) 12/22/11 at 8:00 P.M. he resident on the floorer. The fall follow-up date the lange in his/her care, the gap rivate duty caregive per day, staff should resident with ADLs, stadent every 1-2 hours, the land the family inquired dent to the skilled nurs and the family inquired dent to the skilled nurs are fall), directed no chance every 1-2 hours when the fall), directed no chance every 1-2 hours when the fall follow-up date fall), directed no chance every 1-2 hours when the fall follow-up date fall), directed no chance every 1-2 hours when the fall follow-up date fall follow-up date fall), directed no chance every 1-2 hours when the fall follow-up date fall follow-up date fall), directed no chance every 1-2 hours when the fall follow-up date fall follow-up date fall), directed no chance fall follow-up date fall follow-up date fall follow-up date fall follow-up date fall).	to ck cked falls in ted e ers to aff ne ling in ted inge in no ident, eer in ted nge ent	33133			
		ent and the resident had nental decline and poor					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILANO	OOKKLOHOW	IDENTIFICATION NUMB	EK:	A. BUILDING			
		N046057		B. WING		0.	C
		NU46U57	CTDEET ADD	DECC CITY OF	TE ZID CODE	0,	3/21/2012
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
ABERDEEN VILLAGE			17500 WES OLATHE, K	ST 119TH STR (S 66061	EET		
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
S3155	Continued From page	e 17		S3155			
	The fall report dated	12/28/11 at 4:13 P.M.					
		the resident on the floor	r next				
	to his/her overturned						
		2 (7 days after the fall),					
	_	of care needed, private	-				
		he resident 4 hours per aff did hourly checks wh	•				
	_	it, it was the resident's 2					
	-	the resident had poor					
		er to lock the wheelchai					
	brakes before getting out of the chair, the resident was unable to use his/her walker at that time, and the family would like a bed in the skilled nursing unit for the resident when a bed was available.						
			,				
	-	12/29/11 at 12:05 A.M. the resident on the floor	r half				
		and the resident rubbed	IIali				
		enied pain. The fall follo	ou-wc				
		he fall), directed no cha					
		should continue hourly					
	-	ate duty caregivers we					
		sident's 24th fall in 201					
		d the family wanted a s					
	nursing unit bed for ti	he resident when availa	ible.				
	•	12/29/11 at 6:48 A.M.					
		the resident on the floor					
		I chair. The fall follow-u					
		ted the resident needed re, the family looked into	-				
	•	rs that were not set up					
		e resident every 1-2 ho					
		s the resident's 18th fal					
	family was purchasin						
		chair, and the facility wa	as				
	waiting for therapy to						
	resident's 2nd fall on	this date.)					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		, ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		N046057		A. BUILDING B. WING			C 21/2012
NAME OF PE	ROVIDER OR SUPPLIER	110-10007	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00/1	1/2012
	EN VILLAGE			ST 119TH STR			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S3155	Continued From page	e 18		S3155			
	his/her recliner. The f days after the fall), directeds when no private wheelchair rather that resident's 25th fall arthe family wanted a sthe resident. (This watthis date.) The fall report dated recorded staff found this/her living room. To 12/30/11 directed, no private duty caregiver hours per day, the resident for transpet oask for assistance. fall on this date.) The fall report dated staff found the reside his/her recliner. The f days after the fall), directed his/her recliner. The f days after the fall), directed hour when no caregivers 4 hours per assistance, staff shou hour when no caregiver family wanted a skiller the family wan	the resident on the floor fall follow-up dated 1/5/rected staff continue he ate duty caregiver was ident only use his/her in his/her walker, it was not the 19th this month, killed nursing unit bed fas the resident's 3rd fall 12/29/11 at 4:00 P.M. the resident on the floor he fall follow-up dated or changed of care needers were with the resident used his/her ort and remind the resident (This was the resident' 1/2/12 at 5:15 A.M. recont on the floor in front of fall follow-up dated 1/9/rected the level of care	the and for on in ed, at 4 dent is 4th orded if 12 (7				
	staff found the reside his/her recliner. The f days after the fall), dir checks, use only whe	1/2/12 at 4:15 P.M. recont on the floor in front of fall follow-up dated 1/9/rected staff continue hoselchair for mobility, tryview or with staff if need	f 12 (7 ourly to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
		IDENTIFICATION NOWE	DEN.	A. BUILDING	<u> </u>		С
		N046057		B. WING		03	/21/2012
NAME OF DE	ROVIDER OR SUPPLIER	11040007	STREET ADDI	RESS, CITY, STA	TE ZIP CODE	03	12 1/20 12
NAIVIE OF PE	ROVIDER OR SUPPLIER			T 119TH STR			
ABERDE	EN VILLAGE		OLATHE, K				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S3155	Continued From parand the family required skilled nursing. The fall report date recorded staff foun the foot of the bed. 1/10/12 directed coand staff should charman the family requester skilled nursing unit. The fall report date staff witnessed the behind walker and The fall follow-up dfall), directed privated day, continue hours waited for the resident nursing unit. The fall report date recorded staff foun the foot of the bed. 1/12/12 directed proposed in the A.M., a resident required 1 safety, staff should keep the resident in caregivers were profit.	age 19 Juested the resident moved unit. Ind 1/5/12 at 11:30 A.M. Ind the resident on the floo of the fall follow-up dated ontinue private duty caregivers the resident hourly, and the resident be moved of the fall follow-up dated 1/6/12 at 4:30 P.M. reconsident fell while ambulating the walker grips were loot ated 1/10/12 (4 days after the duty caregivers 4 hours by checks, and the family lent to be moved to the slow of the fall follow-up dated divate duty caregivers for 2 and 2 hours in the evening 2 staff for transfers relating continue hourly checks and staff's view when no	d to r at givers and to the orded ating ase. or the s per killed r at 2 g, the ed to and	S3155			
	should check the re in view of the staff, transfers, the resid skin tears from falls	vers 4 hours per day, staft esident hourly or keep hir 1-2 staff needed for all ent had multiple old and res, and the family waited for ed to the skilled nursing u	n/her new or the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING		03/21/2	2012
NAME OF PE	OVIDER OR SUPPLIER	14040007	STREET ADD	I RESS, CITY, STA	ATE, ZIP CODE	03/21/2	2012
ABERDEEN VILLAGE				T 119TH STR			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S3155	Continued From page	20		S3155			
	facing his/her recliner 1/16/12 (4 days after duty caregivers 4 hou continue frequent hou waited for the residen nursing unit. The fall report dated recorded staff found to his/her bathroom domplained of left leg dated 1/16/12 (3 days change of care needed caregivers 4 hours peankle and negative for waited for the residen nursing unit.	the resident on the floor. The fall follow-up date the fall), directed private rs per day, and staff shurly checks, and the fant to be moved to the skull/13/12 at 4:10 P.M. the resident on the floor oor and the resident pain. The fall follow-up after the fall), directed ed, continue private duties day, x-ray ordered for fracture, and the famit to be moved to the skull/s	ed e nould nily rilled no p no y r left				
	the foot of his/her bed complained of pain in follow-up dated 1/20/directed no change of 2012, family consider caregivers and met w resident had old skin and staff should contiin. The fall report dated recorded staff found the beside his/her recline 1/23/12 (5 days after of care needed, hosp pending family decision.)	he resident on the floor I, and the resident in his/her right foot. The 12 (3 days after the fall) if care needed, 9th fall in ed 24 hour private duty ith hospice providers, to tears from previous fall nue to monitor the resident on the floor in. The fall follow-up dat the fall), directed no choice and 24 hour caregion, 10th incident, the oma on his/her left han	fall), he s, dent. ed nange				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N046057		B. WING			C 21/2012
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ABERDEEN VILLAGE			17500 WES	ST 119TH STR (S 66061	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S3155	Continued From page 21			S3155			
	moved to the skilled r	nursing unit.					
	to his/her bed. The fadays after the fall), din needed, 24 hour priva on 1/20/12, it was the resident had new skir the resident's old skir healing, and the famil be moved to the skilled. The fall report dated recorded staff found this/her desk. The fall days after the fall), din needed, 24 hour priva 1/20/12 at 7:00 A.M., on his/her right thumb tears were healing, the during the fall and stachecks, staff should to	the resident on the floor all follow-up dated 1/24/rected no change in car ate duty caregivers to se resident's 12th incident the tears to his/her right en tears and bruises were ly waited for the residered nursing unit. 1/19/12 at 3:50 P.M. the resident on the floor follow-up dated 1/23/12 rected no change of car ate duty caregivers star the resident had a skin on, the resident hit his/her heaff initiated neurology continue to monitor the aily waited for the reside	12 (5 re tart tt, the lbow, e nt to by 2 (4 re t tear nead				
	Observation on the skilled nursing unit on 3/8/12 at 4:34 P.M. revealed the resident in his/her wheelchair in the living room common area of the unit and bent over in the wheelchair with his/her feet on the floor and reached down and tried to		of the her				
	area asked the reside wheelchair and the re hands. At 4:49 P.M., wheelchair, the left fo the right foot on the fl self-propelled the who	At 4:37 P.M., staff in the ent to sit back in the esident grabbed the state the resident sat in his/hoot on the right footrest,	ff's er and ht				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		` ′	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		N046057		A. BUILDING B. WING			C 21/2012
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	EN VILLAGE		17500 WES OLATHE, K	ST 119TH STR (S 66061	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155	Continued From page	22		S3155			
	control in his/her left I resident had both fee of the footrests, and wheelchair and almos When staff attempted back on the footrests attempted to hit the side the provide increased supervising recommended to the resident move to the of increased supervising recommended to the resident move to the of increased supervising recommended to the resident move to the of increased supervising the skilled nursing 2/2/12. Administrative he/she thought he/she of the resident at ano and did not document he/she identified the supervision than the aprovide. In addition, a recommended the far recliner for the reside electric lift chair safet resident, and the resident, and the resident of the resident of the safely use the election of the safely use the election of the safely use the electron of the resident of the r	hand. At 4:52 P.M., the ton the floor to the righ was sharply turned in the st sat sideways in the class to place the resident's the resident refused an taff with the remote control of 3/14/12 at 8:02 A.M., g staff B stated he/she resident's family that the skilled nursing unit becaused the placement of the ere was not a bed avail unit from 12/14/11 to enursing staff B stated e discussed the placement of that, and acknowledge resident needed more assisted living unit could administrative nursing staff B stated lead in the electric that and did not perform any assessment for the dent fell from the electric knowledged he/she dent's confusion about the tric lift chair controller. If staff B stated he/she dent's confusion about the resident, and the electric lift chair controller. If staff B stated he/she dentification and the resident were in care plan.	at side he hair. feet hair. feet had htrol. he ause e hable hent sure ed d taff B ic lift an ic lift how tried t and t				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		N046057		A. BUILDING B. WING			C 21/2012
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 00/2	
	EN VILLAGE			T 119TH STR			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155	assistance and made (call light) was around During an interview of care staff J stated fall resident included staff dining room and occat the bathroom. During an interview of direct care staff K staff when he/she was on interventions included approximately every I had his/her call button but the resident did not the facility provided to 12/1/96 which directed identified for risk of fair implemented to reduct status would be docut and/or overall plan of interventions to mining would implement a sy	raged him/her to call for sure the resident's per d the resident's neck. In 3/14/12 1:58 P.M., direction interventions for the fine fine fine fine fine fine fine fin	rect the roto Is and dent /she et up, dated	S3155	DEFICIEN	CY)	
		nplement effective ed to provide adequate ependent resident with	a				